

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9514

CERTIFICATE OF DEATH

Reg. Dist. No.

09488

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Grasonville</i>	c. LENGTH OF STAY IN TB <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Grasonville, Md.</i>	d. COUNTY <i>Queen Anne</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>Mary E. Bouldin</i>		4. DATE OF DEATH <i>8 20 1959</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/3/75</i>		
9. AGE (In years from birth) <i>83</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles E. Cooper</i>	14. MOTHER'S MAIDEN NAME <i>Rachael Hazelton, Grasonville, Md.</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>James Bouldin, Grasonville, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Hemorrhage</i> <i>Hypertension</i>	INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>? yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) <i>Georgetown</i>	(County) <i>Queen Anne</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>June 19, 1957</i> , to <i>Aug. 19, 1959</i> that I last saw the deceased alive on <i>Aug. 19, 1959</i> , and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irvin G. Hoyt M.D.</i>					
PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/22/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Grasonville Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Grasonville, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jenck Roselli Ector, m.d.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>AUG 27 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Clinical Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09489

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville		c. LENGTH OF STAY IN 1b 53 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Franklin Last Gardner		4. DATE OF DEATH Aug 26 1959	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct 19 1905	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food	
10c. BIRTHPLACE (State or foreign country) Md.		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Edward Gardner		14. MOTHER'S MAIDEN NAME Sarah Louise King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Nettie Gardner		Address Stevensville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____			
DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Irvin G. Hoyt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Irvin G. Hoyt MD		DATE SIGNED 8/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug 29	
22c. NAME OF CEMETERY OR CREMATORIAL STEVENSVILLE		22d. LOCATION (City, town, or county) STEVENSVILLE (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar H. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DATE SEP 3 '59		24b. REGISTRAR'S SIGNATURE	

STATEMENT OF EXPENSES
MADE DURING THE PAST MONTH
MARCH EXHIBIT CERTIFICATE OF DEAN

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE-
HEALTH DEPT.

Item 18 Film 248 9-16-59 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9516 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 5 Film G248 9-3-59 et

Reg. Dist. No.

19490

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Q A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Grasonville</i>	c. LENGTH OF STAY IN lb <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>—</i>	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Grasonville Md</i>	
d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <i>John</i>	First	Middle	Lost	4. DATE OF DEATH <i>Gibbs</i>	Month	Doy	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	DATE OF BIRTH <i>5</i>	9. AGE (In years last birthday) <i>Aug 6, 1959</i>	IF UNDER 1 YEAR yrs.	IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Tidewater Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
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13. FATHER'S NAME <i>George Gibbs</i>	14. MOTHER'S MAIDEN NAME <i>Joyce B. Gibbs</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Mary Gates Centreville Md</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxemia</i>		
340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		
(b) DUE TO 1. Round cell Meningitis		
(c) 2. Aspiration of mucus - Cause of anoxemia		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		
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ACTUAL SIGNATURE <i>C. R. Layton</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>8-23-59</i>
EXAMINER'S NAME (Type) <i>C. R. Layton</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>8/23/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Grasonville Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Grasonville, Maryland</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar S. Lane</i>	ADDRESS <i>Church Hill Md</i>	24a. REC'D BY REGISTRAR <i>—</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Lane</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

9517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09491

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Queen Anne's MARYLAND		Maryland Q A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Henderson Md 10 yds		x Henderson Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Charles Downs Farm		1 RFD-1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Thomas Clayton Bister		Last	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 29, 1906 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Farm labor		Farming	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Greensboro Md USA		Greensboro Md USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Clarence W Bister		Addie Tribbitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Occlusion 15 hr	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Generalized Atherosclerosis ✓	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
No			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>C. R. Layton</i>		DATE SIGNED Aug 8, 1959	
EXAMINER'S NAME (Type) <i>C. R. Layton</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-12-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greensboro, Md.</i>		22d. LOCATION (City, town, or county) <i>Greensboro, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boelaars</i>		ADDRESS <i>Greensboro, Md.</i>	24a. REC'D BY REGISTRAR DATE AUG 11 '59
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>	

MISSOURI STATE INSURANCE DIVISION
WEDNESDAY, DECEMBER 2, 1942

1942

X 1
FOR STATE
HEALTH DEPT.

9518 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09492

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>		b. COUNTY <i>Queen Anne's</i>	
c. LENGTH OF STAY IN 1b <i>13 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>CHARLES</i>	Middle <i>Edward</i>	Last <i>Lucke, Jr.</i>	4. DATE OF DEATH <i>August 6</i>	Month <i>August</i>	Day <i>6</i>	Year <i>1959</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <i>March 18 - 1905</i>	9. AGE (In years less birthday) <i>54 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Writer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Yachting Magazine</i>	11. BIRTHPLACE (State or foreign country) <i>New York N.Y.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>Charles E Lucke</i>	14. MOTHER'S MAIDEN NAME <i>Ida Becker</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>3</i>	17. INFORMANT <i>Thomas Mervin Lucke Endicott N.Y.</i>	Address <i>15 Allan Valley</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>322.0</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE <i>John G. Hoyt</i>	21d. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>8/6/59</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>Aug 10 - 59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sabrebrake</i>	22d. LOCATION (City, town, or county) (State) <i>Wilmington Delaware</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. G. Hoyt</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>AUG 10 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, sealing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

STATE BOARD OF EXAMINERS OF GEOGRAPHY
EXAMINATIONS FOR CERTIFICATION

STATE BOARD
EXAMINERS OF GEOGRAPHY

EXAMINERS

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Pages 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9519 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09493

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
<i>Queen Anne</i> MARYLAND		<i>Maryland Queen Anne</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY		
<i>Queen Anne</i>	<i>4 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		
<i>R 710 #10</i>		<i>R 710 #1</i>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
<i>Howard</i>	<i>Ross</i>	<i>McDade</i>	<i>Aug 12 1959</i>	
4. DATE OF DEATH	Month	Day	Year	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
<i>Male</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Oct 16 1878 80 yrs.</i>	
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
12. CITIZEN OF WHAT COUNTRY?	Months	Days	Hours	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		Address	
<i>James F. Mcade</i>	<i>Willamina Thomas</i>		<i>None</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
<i>No</i>			<i>Cerebral Encephalitis class 2 mos</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	(b)	DUE TO		
		DUE TO	<i>cerebral arteriosclerosis chronic</i>	
		(c)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Coronary artery disease</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 12 1959</i> that I last saw the deceased alive on <i>Aug 3 1959</i> , and that death occurred at <i>1508</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Quebec Avenue</i> DATE SIGNED <i>8-13</i>		
ACTUAL SIGNATURE <i>Kurt Lederer</i>		M.D.		
PHYSICIAN'S NAME (Type) <i>KURT LEDERER</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 8-18-59</i>		
22b. DATE THEREOF <i>Aug 18 1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Sawmills</i>	22d. LOCATION (City, town, or county) <i>Sawmills, Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles W. Marshall, Shagbark M</i>		ADDRESS <i>9th and Main, Shagbark M</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 14 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Charles W. Marshall</i>

KANSAS STATE DEPARTMENT OF HEALTH—WELFARE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Queen Anne's MARYLAND		Md. Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Queenstown	5 yr.	X Queenstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Middle Last		4. DATE OF DEATH	Month Day Year
Katherine Elizabeth Reese		Aug. 16	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
F	W		July 24-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Dietrich		Elizabeth Lick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT	
No —		None Henry Reese Address Queenstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
543X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
DUE TO Gastrointestinal Hemorrhage 7 hrs.			
Acute Gastritis 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1959, to Aug. 1959, that I last saw the deceased alive on Aug. 15, 1959, and that death occurred at 8 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
Physician's Name (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Aug 19-59	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Chesterfield		Centerville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Edward Baugh, Belton Bros. Caskets, Md.		24a. REC'D BY REGISTRAR DATE AUG 18 '59	
24b. REGISTRAR'S SIGNATURE		Arthur S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9521

CERTIFICATE OF DEATH

Reg. Dist. No. 09495

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Chestertown		c. LENGTH OF STAY IN 1b adult life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RFD from Chestertown Post Office		d. STREET ADDRESS RFD				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home				d. STREET ADDRESS RFD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) J. Earl Smith		First	Middle	Last	4. DATE OF DEATH Aug. 1, 1959	Month	Day	Year 19		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH Dec. 24, 1900	9. AGE (in years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY ret. owner		11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME J. Thomas Smith				14. MOTHER'S MAIDEN NAME Rosa Walls						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-36-1005		17. INFORMANT Mrs. J. Earl Smith		Address Chestertown, Md. RFD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		Carcinomatosis Carcinoma, Left Lung		INTERVAL BETWEEN ONSET AND DEATH 1 year 0 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. p.m.	Month 19	Doy	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 6/11, 1958, to 8-1, 1959, that I last saw the deceased alive on 8-1-59, 1959, and that death occurred at M, from the causes and on the date stated above.										
ACTUAL SIGNATURE Physician's NAME (Type) Robert W. Farr	ADDRESS Chestertown, Md.		DATE SIGNED 8/2/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/4/59	22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Maryland	(State)						
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Wells	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR AUG 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knud							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9522

CERTIFICATE OF DEATH

Reg. Dist. No.

09496

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Queen Anne's MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chester		c. LENGTH OF STAY IN 1b 3 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Chester		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Walton Weldon Thompson		Walton	Weldon
4. DATE OF DEATH		Month	Day Year
		AUG	24 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	B. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Mason		Construction	GRASONSVILLE, MARYLAND
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Edward S. Thompson		MARY E. TARR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
YES		220-01-8527	OREM A. Thompson, Chester, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 8-19-59 → P 2459	
581.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Delirium Tremens DUE TO (c) Liver Complns (Jaundice)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-19, 1959, to 8-23, 1959, that I last saw the deceased alive on 8-23, 1959, and that death occurred at 2-30 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8-24-59	
ACTUAL SIGNATURE LUCI BALDI MD.		DATE SIGNED	
PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 27-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National
22d. LOCATION (City, town, or county) Arlington		(State) Va	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Bunting, Bunting Brothers, Centerville, Maryland		24a. REC'D BY REGISTRAR AUG 31 '59	24b. REGISTRAR'S SIGNATURE Arthur & Anna

